Vivitrol® Enrollment Form

Fax Referral To: 207.899.0968
Phone: 207.899.0939
Email Referral To:
benefitscoordinationteam@abdrx.com

Six Simple Steps to Submitting a Referral

❶ PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________
Address: ______________________
City, State, ZIP: ______________________
Preferred Contact Method: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: __________ ☐ Home ☐ Cell ☐ Work
Alternate Phone: __________ ☐ Home ☐ Cell ☐ Work
DOB: __________ Gender: ☐ Male ☐ Female
Email: ______________________
Last Four of SSN: __________ Primary Language: __________

❷ PRESCRIBER INFORMATION

Prescriber's Name:
State License #: __________ NPI #: __________
DEA #: __________
Group or Hospital: ______________________
Address: ______________________
City, State, ZIP: ______________________
Phone: ______________________
Fax: ______________________
Contact Person: ______________________
Contact's Phone: ______________________

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

❹ DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: __________ Ship to: ☐ Patient ☐ Office ☐ Other: __________

Diagnosis (ICD-10): **Date of Diagnosis:** ____________________

Alcohol Dependence	Opioid Dependence
ICD-10	ICD-10
F10.__________	F11.__________
F10.__________	F11.__________
F10.__________	F11.__________
F10.__________	F11.__________
F10.__________	F11.__________
Other __________	Other __________

☐ Other: ____

☐ ICD-10 Code & Description: ____

Patient Clinical Information:
Weight: _______ lb/kg Height: _______ in/cm
Allergies: ____

❺ PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Vivitrol	☐ 380 mg vial Kit *(for intramuscular injection)*	☐ Administer 380 mg intramuscularly *every 4 weeks (28 days).* ☐ Other: ____________	☐ One 380 mg vial kit *(includes supplies)* -- see below* ☐ Other: ________	
☐ ____________				

*Vivitrol Kit includes:
- Vial of Vivitrol microspheres
- Vial of diluent
- One 20 G ½" preparation needle
- Two 20 G 1&½" administer needles

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

❻ x ______________________________ x ______________________________
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.

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